CONTINUING EDUCATION ADVISORY COUNCIL
MONTANA BOARD OF PHARMACY
PO BOX 200513
HELENA MT 59620-0513
Phone 406-841-2356 Fax 406-841-2305

PROGRAM APPROVAL FORM

Please Type or Print Clearly

Applying For:
☐ Group Credit
☐ Individual Credit

Person Requesting Approval _____ Phone _____

Mailing Address_____ City_____ State _____ Zip _____

Name of Course Provider _____ Phone_____

Mailing Address _____ City _____ State _____ Zip _____

Title of Program _____

Presentation Location _____ City _____ State _____ Zip _____

Date of Presentation _____ Registration Fee_____

Estimated number of professionals participating: _____ Pharmacists _____ Physicians _____ Nurses _____ Others_____

Location of attendance records _____

SUBJECT	INSTUCTOR	FORMAT	CLOCK HOURS

REQUIREMENTS:

1. **Provider must maintain record of program, program approval number, and names and addresses of participants for 3 years.**
2. **Provider must award a certificate that includes all information required by the "Program Approval Guidelines" listed under I (Approval Process).**
3. **Provider must submit the approval form at least 30 days prior to the date of program. Failure to do so exposes participants to risk of disallowance of credit if program is found unacceptable.**
4. **Please enclose a copy of any brochures, program schedules, etc. describing the program.**

CEAC # _____ Approval Date _____ Reviewers Initials ____